

AMENDED IN SENATE MAY 18, 1999  
AMENDED IN SENATE APRIL 28, 1999  
AMENDED IN SENATE MARCH 25, 1999

**SENATE BILL**

**No. 59**

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**Introduced by Senators Perata and Ortiz**  
(Principal coauthor: Assembly Member Thomson)  
(Coauthor: Assembly Member Alquist)

December 7, 1998

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An act to add Section 1363.51 to the Health and Safety Code, to add Section 10123.135 to the Insurance Code, and to add Section 14087.41 to the Welfare and Institutions Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 59, as amended, Perata. Health care coverage.

(1) Existing law provides for the regulation of health care service plans by the Department of Corporations and for the regulation of disability insurers by the Department of Insurance. Existing law requires a health care service plan to disclose the process used by the plan to authorize or deny health care services, to the Commissioner of Corporations, health care providers under contract with the plan, and enrollees, as specified. Existing law requires a health care service plan and a disability insurer to include within its disclosure form and evidence or certificate of coverage a statement describing how participation may affect the choice of physicians. Existing law provides that a willful violation of provisions regulating health care service plans is a crime.

This bill would enact additional provisions applicable to a health care service plan that prospectively or concurrently reviews and approves, modifies, or denies, based on medical necessity or appropriateness, requests by providers prior to, or concurrent with, the provision of health care services to enrollees. It would require that those decisions be made within specified timeframes. These provisions would not apply to certain decisions made for the care or treatment of the sick who depend upon prayer or spiritual means for healing in the practice of religion. The bill would also enact similar provisions applicable to a disability insurer that prospectively or concurrently reviews and approves, modifies, or denies, based on medical necessity or appropriateness, requests by providers prior to, or concurrent with, the provision of health care services to insureds. It would require that those decisions be made within specified timeframes. Because a violation of the bill's requirements with respect to health care service plans would be a crime, this bill would create a state-mandated local program by creating a new crime.

This bill would also make legislative findings and declarations in this regard.

(2) Existing law provides for the Medi-Cal program to provide health coverage for low-income persons.

This bill would require the State Department of Health Services to develop a simple form to be used by Medi-Cal managed care plans in order to notify an enrollee of a denial, termination, delay, or reduction in benefits, as specified.

(3) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.



*The people of the State of California do enact as follows:*

SECTION 1. (a) The Legislature finds and declares all of the following:

(1) Consumers have the right to receive quality medical care in a timely and efficient manner.

(2) Decisions about medical care should be made by physicians and other relevant health care professionals.

(3) Consumers have the right to know how and why a decision about their medical care is made.

(b) “Utilization review,” otherwise known as “internal review,” is the process by which health care service plans and disability insurers review, and approve, modify, or deny, requests for treatment of patients by physicians, and the Legislature recognizes that it is an integral component of the total process by which consumers access health care services.

SEC. 2. It is the intent of the Legislature to establish sound consumer protections applicable to the internal review processes of health care service plans and disability insurers, with the goal of providing faster, more accessible, and better quality medical care to patients, with these consumer protections to include all of the following:

(a) A guaranteed time limit on the internal review process for requested health care services, not to exceed 72 hours for urgent health care service requests and five days for other requests.

(b) Physician oversight of the internal review process for requested health care services, or oversight by a licensed health care professional with relevant expertise.

(c) Denial of care only when supported by clinical criteria and only when the denial is approved by physicians or other licensed health care professionals with relevant expertise.

SEC. 3. Section 1363.51 is added to the Health and Safety Code, to read:

1363.51. (a) Every health care service plan that prospectively or concurrently reviews and approves, modifies, or denies, based in whole or in part on medical

1 necessity or appropriateness, requests by providers prior  
2 to, or concurrent with, the provision of health care  
3 services to enrollees, or that delegates these functions to  
4 contracting providers, shall comply with this section.

5 (b) A health care service plan that is subject to this  
6 section shall have written policies and procedures  
7 establishing the process by which the plan prospectively  
8 or concurrently reviews and approves, modifies, or  
9 denies, based in whole or in part on medical necessity or  
10 appropriateness, requests by providers of health care  
11 services for plan enrollees. These policies and procedures  
12 shall ensure that decisions based on the medical necessity  
13 or appropriateness of proposed health care services are  
14 supported by criteria developed pursuant to Section  
15 1363.5. These policies and procedures, and a description  
16 of the process by which the plan reviews and approves,  
17 modifies, or denies requests by providers prior to, or  
18 concurrent with, the provision of health care services to  
19 enrollees, shall be filed with the commissioner for review  
20 and approval, and shall be disclosed by the plan to  
21 providers and enrollees upon request, and by the  
22 commissioner to the public upon request.

23 (c) Every health care service plan subject to this  
24 section shall employ or designate a medical director who  
25 holds an unrestricted license to practice medicine in this  
26 state issued pursuant to Section 2050 of the Business and  
27 Professions Code or pursuant to the Osteopathic Act, or,  
28 if the plan is a specialized health care service plan, a  
29 clinical director with California licensure in a clinical area  
30 appropriate to the type of care provided by the  
31 specialized health care service plan. The medical director  
32 or clinical director shall ensure that the process by which  
33 the plan reviews and approves, modifies, or denies, based  
34 in whole or in part on medical necessity or  
35 appropriateness, requests by providers prior to, or  
36 concurrent with, the provision of health care services to  
37 enrollees, complies with the requirements of this section.

38 (d) If health plan personnel, or individuals under  
39 contract to the plan to review requests by providers,  
40 approve the provider's request, pursuant to subdivision

(b), the decision shall be communicated to the provider pursuant to subdivision (h).

(e) No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity or appropriateness. In cases in which the request by a provider for authorization of health care services for an enrollee is not approved by the individual reviewing the request, the request shall be reviewed, based on clinical criteria, by a physician who holds a current, unrestricted license to practice medicine in one or more states of the United States, or by a licensed health care professional who is competent to evaluate the specific clinical issues involved in the service requested by the provider. The decision of the physician or other health care professional shall be communicated to the provider and the enrollee pursuant to subdivision (h).

(f) If the health care service plan uses clinical criteria to determine whether to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, the criteria shall be developed pursuant to the requirements of Section 1363.5.

(g) If the health care service plan requests medical information from providers in order to determine whether to approve, modify, or deny requests for authorization, the plan shall request only the information reasonably necessary to make the determination.—~~The plan shall reimburse providers for the reasonable cost of medical record duplication.~~

(h) In determining whether to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, based in whole or in part on medical necessity or appropriateness, every health care service plan subject to this section shall meet the following requirements:

1 (1) Decisions to approve, modify, or deny, based on  
2 medical necessity or appropriateness, requests by  
3 providers prior to, or concurrent with, the provision of  
4 health care services to enrollees that do not meet the  
5 requirements for the 72-hour review required by  
6 paragraph (2), shall be made in a timely fashion  
7 appropriate for the nature of the enrollee's condition, not  
8 to exceed five business days from the plan's receipt of the  
9 information reasonably necessary and requested by the  
10 plan to make the determination.

11 (2) When the enrollee's condition is such that the  
12 enrollee faces an imminent and serious threat to his or her  
13 health, including, but not limited to, the potential loss of  
14 life, limb, or other major bodily function, or the normal  
15 timeframe for the decisionmaking process, as described  
16 in paragraph (1), would be detrimental to the enrollee's  
17 life or health or could jeopardize the enrollee's ability to  
18 regain maximum function, decisions to approve, modify,  
19 or deny requests by providers prior to, or concurrent  
20 with, the provision of health care services to enrollees,  
21 shall be made in a timely fashion appropriate for the  
22 nature of the enrollee's condition, not to exceed 72 hours  
23 after the plan's receipt of the information reasonably  
24 necessary and requested by the plan to make the  
25 determination. Nothing in this section shall be construed  
26 to alter the requirements of subdivision (b) of Section  
27 1371.4.

28 (3) Decisions to approve, modify, or deny requests by  
29 providers for authorization prior to, or concurrent with,  
30 the provision of health care services to enrollees shall be  
31 communicated to the requesting provider within 24  
32 hours of the decision. Except for concurrent review  
33 decisions pertaining to care that is underway, which shall  
34 be communicated to the enrollee's treating provider  
35 within 24 hours, decisions resulting in denial or  
36 modification of all or part of the requested health care  
37 service shall be communicated to the enrollee in writing  
38 within two business days of the decision. In the case of  
39 concurrent review, care shall not be discontinued until



1 the enrollee's treating provider has been notified of the  
2 plan's decision.

3 (4) Communications regarding decisions to approve  
4 requests by providers prior to, or concurrent with, the  
5 provision of health care services to enrollees, shall specify  
6 the specific health care service approved. Responses  
7 regarding decisions to deny or modify health care  
8 services requested by providers prior to, or concurrent  
9 with, the provision of health care services to enrollees,  
10 shall be communicated to the enrollee in writing and to  
11 providers initially by telephone and then in writing, and  
12 shall include a clear and concise explanation of the  
13 reasons for the plan's response, describe the criteria used  
14 and the clinical reasons for the decisions regarding  
15 medical necessity or appropriateness. Responses shall also  
16 include information as to how the enrollee may file a  
17 grievance with the plan pursuant to Section 1368, and in  
18 the case of Medi-Cal enrollees, shall explain how to  
19 request an administrative hearing and aid paid pending  
20 under Sections 51014.1 and 51014.2 of Title 22 of the  
21 California Code of Regulations.

22 (5) If the health care service plan cannot make a  
23 decision to approve, modify, or deny the request for  
24 authorization within the timeframes specified in  
25 paragraph (1) or (2) because the plan is not in receipt of  
26 all of the information reasonably necessary and  
27 requested, or because the plan requires consultation by  
28 an expert reviewer, or because the plan has asked that an  
29 additional examination or test be performed upon the  
30 enrollee, provided the examination or test is reasonable  
31 and consistent with good medical practice, the plan shall,  
32 immediately upon the expiration of the timeframe  
33 specified in paragraph (1) or (2) or as soon as the plan  
34 becomes aware that it will not meet the timeframe,  
35 whichever occurs first, notify the provider and the  
36 enrollee, in writing, that the plan cannot make a decision  
37 to approve, modify, or deny the request for authorization  
38 within the required timeframe, and specify the  
39 information requested but not received, or the expert  
40 reviewer to be consulted, or the additional examinations

1 or tests required. The plan shall also notify the provider  
2 and enrollee of the anticipated date on which a decision  
3 may be rendered. Upon receipt of all information  
4 reasonably necessary and requested by the plan, the plan  
5 shall approve, modify, or deny the request for  
6 authorization within the timeframes specified in  
7 paragraph (1) or (2), whichever applies.

8 (6) Except as specified in paragraph (5), a plan's  
9 failure to meet the timeframes specified in paragraph (1)  
10 or (2), whichever applies, shall be deemed to be an  
11 authorization to the provider to proceed with the  
12 requested health care services. Prior to proceeding with  
13 the service that is deemed to be authorized, the provider  
14 shall notify the plan within one business day to: (A)  
15 confirm that the timeframe has expired, (B) provide  
16 enrollee identification, and (C) provide notification of  
17 the place of service and of the provider or providers  
18 performing the service or services. The plan shall provide  
19 the provider with an acknowledgment of that notification  
20 within one business day of receiving it.

21 *For purposes of this paragraph, the provision of health*  
22 *care services that are deemed to be authorized shall not*  
23 *create any basis of liability against the plan, provided the*  
24 *plan does not specify or direct the duration or manner in*  
25 *which the health care services were provided.*

26 (i) Every health care service plan subject to this  
27 section shall maintain telephone access during normal  
28 business hours for providers to request authorization for  
29 health care services.

30 (j) Every health care service plan subject to this  
31 section that reviews requests by providers prior to, or  
32 concurrent with, the provision of health care services to  
33 enrollees shall establish, as part of the quality assurance  
34 program required by Section 1370, a process by which the  
35 plan's compliance with this section is assessed and  
36 evaluated. The process shall include provisions for  
37 evaluation of complaints, assessment of trends,  
38 implementation of actions to correct identified problems,  
39 mechanisms to communicate actions and results to the  
40 appropriate health plan employees and contracting



1 providers, and provisions for evaluation of any corrective  
2 action plan and measurements of performance.

3 The commissioner shall review a health care service  
4 plan's compliance with this section as part of its periodic  
5 onsite medical survey of each plan undertaken pursuant  
6 to Section 1380, and shall include a discussion of  
7 compliance with this section as part of its report issued  
8 pursuant to that section.

9 (k) This section shall not apply to decisions made for  
10 the care or treatment of the sick who depend upon prayer  
11 or spiritual means for healing in the practice of religion  
12 as set forth in subdivision (a) of Section 1270, or in any  
13 way interfere with provisions set forth in Sections 2063  
14 and 2731 of the Business and Professions Code.

15 *(l) Nothing in this section shall cause a health care*  
16 *service plan to be defined as a health care provider for*  
17 *purposes of any provision of law, including, but not*  
18 *limited to, Section 6146 of the Business and Professions*  
19 *Code, Sections 3333.1 and 3333.2 of the Civil Code, and*  
20 *Sections 340.5, 364, 425.13, 667.7, and 1295 of the Code of*  
21 *Civil Procedure.*

22 SEC. 4. Section 10123.135 is added to the Insurance  
23 Code, to read:

24 10123.135. (a) Every disability insurer that covers  
25 hospital, medical, or surgical expenses and that  
26 prospectively or concurrently reviews and approves,  
27 modifies, or denies, based in whole or in part on medical  
28 necessity or appropriateness, requests by providers prior  
29 to, or concurrent with, the provision of health care  
30 services to insureds, or that delegates these functions to  
31 contracting providers, shall comply with this section.

32 (b) A disability insurer that is subject to this section  
33 shall have written policies and procedures establishing  
34 the process by which the insurer prospectively or  
35 concurrently reviews and approves, modifies, or denies,  
36 based in whole or in part on medical necessity or  
37 appropriateness, requests by providers of health care  
38 services for insureds. These policies and procedures shall  
39 ensure that decisions based on medical necessity or  
40 appropriateness of a proposed health care service are

1 supported by criteria developed pursuant to subdivision  
2 (f). These policies and procedures, and a description of  
3 the process by which an insurer reviews and approves,  
4 modifies, or denies requests by providers prior to, or  
5 concurrent with, the provision of health care services to  
6 insureds, shall be filed with the commissioner, and shall  
7 be disclosed to insureds and providers upon request, and  
8 by the commissioner to the public upon request.

9 (c) If the number of insureds covered under health  
10 benefit plans in this state that are issued by an insurer  
11 subject to this section constitute at least 50 percent of the  
12 number of insureds covered under health benefit plans  
13 issued nationwide by that insurer, the insurer shall  
14 employ or designate a medical director who holds an  
15 unrestricted license to practice medicine in this state  
16 issued pursuant to Section 2050 of the Business and  
17 Professions Code or the Osteopathic Act, or the insurer  
18 may employ a clinical director licensed in California  
19 whose scope of practice under California law includes the  
20 right to independently perform all those services covered  
21 by the insurer. The medical director or clinical director  
22 shall ensure that the process by which the insurer reviews  
23 and approves, modifies, or denies, based in whole or in  
24 part on medical necessity or appropriateness, requests by  
25 providers prior to, or concurrent with, the provision of  
26 health care services to insureds, complies with the  
27 requirements of this section. Nothing in this subdivision  
28 shall be construed as restricting the existing authority of  
29 the Medical Board of California.

30 (d) If an insurer subject to this section, or individuals  
31 under contract to the insurer to review requests by  
32 providers, approve the provider's request for  
33 authorization, pursuant to subdivision (b), the decision  
34 shall be communicated to the provider pursuant to  
35 subdivision (h).

36 (e) No individual, other than a licensed physician or a  
37 licensed health care professional who is competent to  
38 evaluate the specific clinical issues involved in the health  
39 care services requested by the provider, may deny or  
40 modify requests for authorization of health care services



1 for an insured for reasons of medical necessity or  
2 appropriateness. In cases in which the request by a  
3 provider for authorization of health care services for an  
4 insured is not approved by the individual reviewing the  
5 request, the request shall be reviewed, based on clinical  
6 criteria, by a physician who holds a current, unrestricted  
7 license to practice medicine in one or more states of the  
8 United States, or by a licensed health care professional  
9 who is competent to evaluate the specific clinical issues  
10 involved in the health care services requested by the  
11 provider. The decision of the physician or other health  
12 care provider shall be communicated to the provider and  
13 the insured pursuant to subdivision (h).

14 (f) If an insurer subject to this section uses clinical  
15 criteria to determine whether to approve, modify, or  
16 deny requests by providers prior to, or concurrent with,  
17 the provision of health care services to insureds, the  
18 criteria shall:

19 (1) Be developed with involvement from actively  
20 practicing health care providers.

21 (2) Be developed using sound clinical principles and  
22 processes.

23 (3) Be evaluated, and updated if necessary, at least  
24 once annually.

25 (g) If an insurer subject to this section requests  
26 medical information from providers in order to  
27 determine whether to approve, modify, or deny requests  
28 for authorization, the insurer shall request only the  
29 information reasonably necessary to make the  
30 ~~determination. The insurer shall reimburse providers for~~  
31 ~~the reasonable cost of medical record duplication.~~  
32 ~~determination.~~

33 (h) In determining whether to approve, modify, or  
34 deny requests by providers prior to, or concurrent with,  
35 the provision of health care services to insureds, based in  
36 whole or in part on medical necessity or appropriateness,  
37 every insurer subject to this section shall meet the  
38 following requirements:

39 (1) Decisions to approve, modify, or deny, based on  
40 medical necessity or appropriateness, requests by

1 providers prior to, or concurrent with, the provision of  
2 health care services to insureds that do not meet the  
3 requirements for the 72-hour review required by  
4 paragraph (2), shall be made in a timely fashion  
5 appropriate for the nature of the insured's condition, not  
6 to exceed five business days from the insurer's receipt of  
7 the information reasonably necessary and requested by  
8 the insurer to make the determination.

9 (2) When the insured's condition is such that the  
10 insured faces an imminent and serious threat to his or her  
11 health, including, but not limited to, the potential loss of  
12 life, limb, or other major bodily function, or the normal  
13 timeframe for the decisionmaking process, as described  
14 in paragraph (1), would be detrimental to the insured's  
15 life or health or could jeopardize the insured's ability to  
16 regain maximum function, decisions regarding medical  
17 necessity or appropriateness pursuant to this section shall  
18 be made in a timely fashion, appropriate for the nature of  
19 the insured's condition, but not to exceed 72 hours of the  
20 insurer's receipt of the information reasonably necessary  
21 and requested by the insurer to make the determination.

22 (3) Decisions to approve, modify, or deny requests by  
23 providers prior to, or concurrent with, the provision of  
24 health care services to insureds shall be communicated to  
25 the requesting provider within 24 hours of the decision.  
26 Except for concurrent review decisions pertaining to  
27 care that is underway, which shall be communicated to  
28 the insured's treating physician within 24 hours, decisions  
29 resulting in denial or modification of all or part of the  
30 requested health care service shall be communicated to  
31 the insured in writing within two business days of the  
32 decision. In the case of concurrent review, health care  
33 services shall not be discontinued until the insured's  
34 treating provider has been notified of the insurer's  
35 decision.

36 (4) Communications regarding decisions to approve  
37 requests by providers prior to, or concurrent with, the  
38 provision of health care services to insureds, shall specify  
39 the specific health care service approved. Responses  
40 regarding decisions to deny or modify health care



1 services requested by providers prior to, or concurrent  
2 with, the provision of health care services to insureds,  
3 shall be communicated to insureds in writing and may be  
4 communicated to providers initially by telephone but  
5 shall thereafter be communicated in writing, shall  
6 include a clear and concise explanation of the reasons for  
7 the insurer's response, and shall describe the criteria used  
8 and the clinical reasons for the decisions regarding  
9 medical necessity or appropriateness. Responses shall also  
10 include information as to how the provider or the insured  
11 may file an appeal with the insurer or seek department  
12 review under the unfair practices provisions of Article 6.5  
13 (commencing with Section 790) of Chapter 1 of Part 7 of  
14 Division 1 and the regulations adopted thereunder.

15 (5) If the insurer cannot make a decision to approve,  
16 modify, or deny the request for authorization within the  
17 timeframes specified in paragraph (1) or (2) because the  
18 insurer is not in receipt of all of the information  
19 reasonably necessary and requested, or because the  
20 insurer requires consultation by an expert reviewer, or  
21 because the insurer has asked that an additional  
22 examination or test be performed upon the insured,  
23 provided that the examination or test is reasonable and  
24 consistent with good medical practice, then the insurer  
25 shall, immediately upon the expiration of the timeframe  
26 specified in paragraph (1) or (2), or as soon as the insurer  
27 becomes aware that it will not meet the timeframe,  
28 whichever occurs first, notify the provider and the  
29 insured, in writing, that the insurer cannot make a  
30 decision to approve, modify, or deny the request for  
31 authorization within the required timeframe, and specify  
32 the information requested but not received, or the expert  
33 reviewer to be consulted, or the additional examination  
34 or test required. Upon receipt of all information  
35 reasonably necessary and requested by the insurer, the  
36 insurer shall approve, modify, or deny the request for  
37 authorization within the timeframes specified in  
38 paragraph (1) or (2), whichever applies.

39 (6) Except as specified in paragraph (5), an insurer's  
40 failure to meet the timeframes specified in paragraph (1)

1 or (2), whichever applies, shall be deemed to be an  
2 authorization to the provider to proceed with the  
3 requested health care services, which shall be deemed to  
4 be a medically necessary or appropriate service for a  
5 requested health care service as required in the policy. All  
6 other terms and conditions of the policy shall apply. Prior  
7 to proceeding with the authorized service, the provider  
8 shall notify the insurer within one business day to: (A)  
9 confirm that the timeframe has expired, (B) provide  
10 insured identification, and (C) provide notification of the  
11 place of service and of the provider or providers  
12 performing service or services. The insurer shall provide  
13 the provider with an acknowledgment of that notification  
14 within one business day of receiving it.

15 *For purposes of this paragraph, the provision of health*  
16 *care services that are deemed to be authorized shall not*  
17 *create any basis of liability against the insurer, provided*  
18 *the insurer does not specify or direct the duration or*  
19 *manner in which the health care services were provided.*

20 (i) Every insurer subject to this section shall maintain  
21 telephone access during normal business hours for  
22 providers to request authorization for health care  
23 services.

24 (j) *Nothing in this section shall cause a disability*  
25 *insurer to be defined as a health care provider for*  
26 *purposes of any provision of law, including, but not*  
27 *limited to, Section 6146 of the Business and Professions*  
28 *Code, Sections 3333.1 and 3333.2 of the Civil Code, and*  
29 *Sections 340.5, 364, 425.13, 667.7, and 1295 of the Code of*  
30 *Civil Procedure.*

31 SEC. 5. Section 14087.41 is added to the Welfare and  
32 Institutions Code, to read:

33 14087.41. The department shall develop a simple  
34 form, consistent with the notice requirements of Sections  
35 51014.1 and 51014.2 of Title 22 of the California Code of  
36 Regulations, for Medi-Cal managed care plans to use to  
37 notify a Medi-Cal enrollee of a denial, termination, delay,  
38 or reduction in benefits. The department shall require all  
39 Medi-Cal managed care plans to use the form as a  
40 condition of participation in Medi-Cal managed care

1 pursuant to any contract negotiated after the effective  
2 date of this section.

3 SEC. 6. No reimbursement is required by this act  
4 pursuant to Section 6 of Article XIII B of the California  
5 Constitution because the only costs that may be incurred  
6 by a local agency or school district will be incurred  
7 because this act creates a new crime or infraction,  
8 eliminates a crime or infraction, or changes the penalty  
9 for a crime or infraction, within the meaning of Section  
10 17556 of the Government Code, or changes the definition  
11 of a crime within the meaning of Section 6 of Article  
12 XIII B of the California Constitution.

